

Unrepresented Residents How Can Bioethics Improve Compliance and Risk Management?

AHLA Long-Term Care and the Law 2021

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2

Importance of
bioethics for
post-acute &
long-term care



3

Objectives



4

5



5

Value of Bioethics



6

How bioethics committees and clinical ethics consultants advance **risk management and compliance** objectives in PA-LTC



7

Key Guidance



8

New laws, regulations, and policy statements on decision making for **incapacitated residents without surrogates** (unrepresented or unbefriended residents)



9

Role of Bioethics



10

How bioethics **protects resident rights**, especially regarding informed consent and end-of-life treatment



11

Surrogates & Proxies



12

How bioethics helps **identify surrogate decision makers** and resolve surrogate conflicts without the time and expense of guardianship or conservatorship



13

Implementation Strategies



14

Helpful pointers and considerations for **establishing a bioethics committee** or for contracting for clinical ethics consultation services



15

Prevalence



16

Bioethics is **rare** in PA-LTC



17

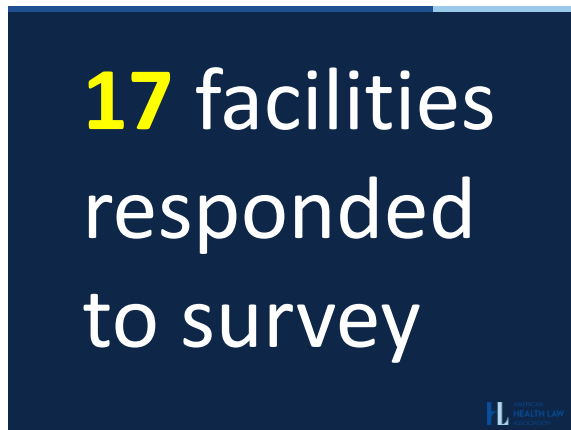
Surveys



18



19



20



21



22

Table 5. Availability of mechanisms to address

Mechanism	Hospital %
Institutional Ethics Committee	96.0
Institutional Risk Management Officer	92.0
Consultation with Peers	96.0
Consultation or Decision by Chief Medical Officer	72.0
Obtain a Guardian	100.0

23

Table 5. Availability of mechanisms to address issues with unrepres

Mechanism	Hospital %	Long term Care %
Institutional Ethics Committee	96.0	60.0
Institutional Risk Management Officer	92.0	51.4
Consultation with Peers	96.0	76.5
Consultation or Decision by Chief Medical Officer	72.0	84.8

24

Other assessments



25

Caring *for the Ages*

When There Is No Ethics Committee



By Jeffrey Nichols, MD

26

Ethics support in institutional elderly care: a review of the literature

Sandra van der Dam,¹ Bert Molewijk,^{2,3} Guy A M Widdershoven,³ Tineke A Abma³

To cite: van der Dam S, Molewijk B, Widdershoven GAM, et al. *J Med Ethics* 2014;**40**: 625–631.



27

“CECs are still an **uncommonly** used tool of nursing homes”



28

CEC prevalence **varies** geographically



29

4 main reasons



30

1 Statutory mandates



31



32

Md. Health-Gen Code
§ 19-371

N.J. Stat. 26 § 2H-65

N.Y. Pub. H. Code 2994m



33

Flexibility in
how fulfill
mandate



34

PA-LTC committee may function

- (1) Solely at that . . . institution
- (2) **Jointly** with a hospital advisory committee
- (3) **Jointly** with . . . committee representing no more than 30 other . . . institutions.



35



36 | 2/10/2021



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Regional Ethics Committees

New Jersey
L.A.C.O.
 Long-Term Care Ombudsman
 1-877-582-6995
 Guidance. Support. Advocacy.

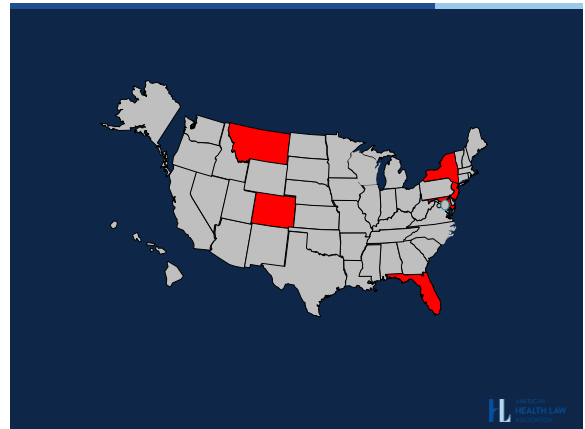
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In addition to statutory mandates

38

2 Statutorily delegated roles & functions

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We'll come back to those roles

41

3 Accreditation mandates

42



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43



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45



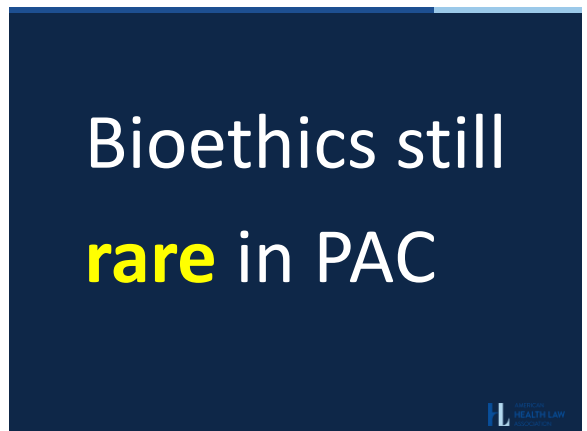
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46



47



48



49

Does **your** client
have a bioethics
committee?

50

Is it your own
or **shared**?
(with H or other PA-LTC?)

51

What **benefits**
does your HEC
provide?

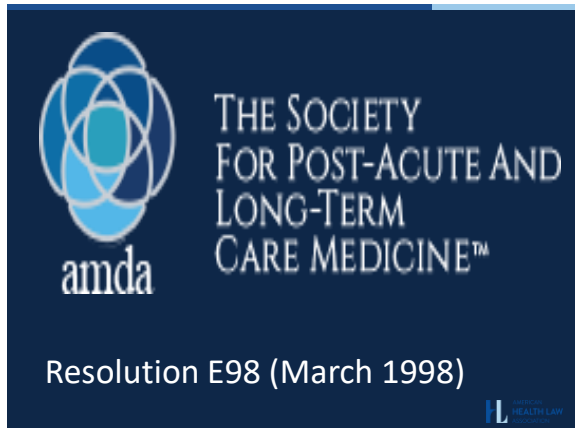
52

Value

53

Value for PA-LTC
recognized over
20 years ago

54



55

Provider

LONG TERM & POST-ACUTE CARE

Bioethics in Post-Acute and Long Term Care

A special interdisciplinary committee can provide guidance and support for difficult clinical decisions providers and families may face.

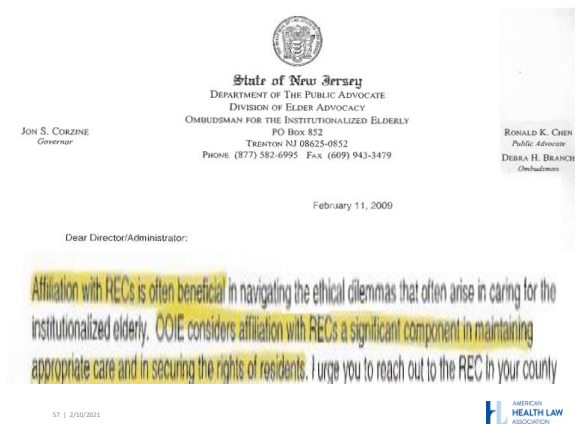
FEBRUARY 2019

Karl Steinberg, MD, CMD

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56



57



58

“The benefits of CECs . . . include

- Support for professionals and families in decision making
- Encouraging moral behavior
- Quality improvement
- Reduction in litigation
- Multidisciplinary consideration of ethical issues

59

Extrapolate
research from
hospital setting –
where there is
more research

60

Outcomes of Ethics Consultations in Adult ICUs: A Systematic Review and Meta-Analysis

Au, Selena S. MD, FRCPC, MSc¹; Couillard, Philippe MD, FRCPC^{1,2}; Roze des Ordon, Amanda MD, FRCPC, MMed^{1,3}; Fiest, Kirsten M. PhD^{1,4,5,6}; Lorenzetti, Dianne L. PhD⁴; Jette, Nathalie MD, FRCPC, MSc²

Critical Care Medicine: February 1, 2018 - Volume Online First - Issue - p
doi: 10.1097/CCM.0000000000002999

61

Meta-review looked at
16 studies 1988 to 2015

Assessed **outcomes** after
clinical ethics
consultations in the ICU



62

6 main
benefits



63

Higher
surrogate &
patient
satisfaction



64

Consensus
more often
achieved



65

Less
litigation



66

If litigation,
courts **defer**
to CEC



67

Lower
resource
utilization



68

Lower staff
moral distress



69

That's **ICU**
where most
bioethics
consults go



70

There are **some**
PA-LTC studies



71

show **same**
benefits



72

Ethical challenges in nursing homes – staff’s opinions and experiences with systematic ethics meetings with participation of residents’ relatives

Georg Bollig MD, MAS (PhD Candidate, Consultant)^{1,2,3}, Gerda Schmidt RN, MAS (Ward Manager, Nursing Manager Representative)⁴, Jan Henrik Rosland MD, PhD (Professor, Director, Chief Physician)^{1,2,5} and Andreas Heller PhD, MA (Professor)⁶

73

“lead to **consent** on acceptable decisions . . . **agreement** acceptable for all involved parties”

74

Let’s move
to more concrete
examples

75

Functions

76

3

77

Education
Policies
Consults

78

Case consult
“main” function



79

Typically
prospective



80

Sometimes
retrospective



81

Let's focus on the
case consult role
of the CEC



82

Issues



83

What does a
PA-LTC bioethics
committee **do**?



84

Resolve
conflicts

Navigate
uncertainty



85

About

what?



86

4 areas



87

Everyday ethics
Ordinary healthcare
End of Life
Surrogates



88

1 Everyday
ethics



89

Sex
Noncompliance
Racist requests



90


18 CARING FOR THE AGES OCTOBER 2020

MEDICAL ETHICS
By Elaine Healy, MD, FACP, CMD

Intimacy and Dementia in Long-Term Care: Time for a Revisit


“When a nonresident spouse or family member **objects** to a developing sexual relationship”

91 | 2/10/2021




91

Optimal clinical care
vs.
resident rights



92

R at risk choking
Requests normal consistency diet



93




94

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/06/2021
Form Approved OMB
No. 0938-0391


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER NM Behavioral Health Institute at Las Vegas(the)		STREET ADDRESS, CITY, STATE, ZIP CODE 3695 Hot Springs Boulevard Las Vegas, NM 87701	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.		



95

“We **locked** his closet door”

“It has not gone to the ethics committee”



96

2

Ordinary healthcare

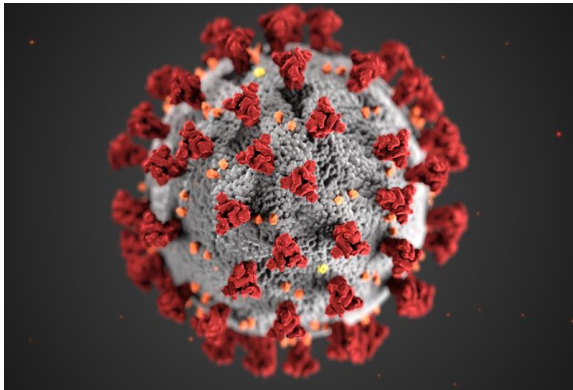


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Covert medication
Coercion/restraints
Lack of time



98



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99

“Limited, rationed, or non-existent supplies and resources . . . have forced . . . ethical decisions regarding **who does and does not receive** testing, medication, a bed . . . other required care.”

Source: PYA



100

“**ethics committee** . . . help balance those decisions; evaluate resources, staffing, supply and equipment rationing . . .”

Source: PYA



101

3

End of Life



102

Advance
directives
POLST



103

Completing
Interpreting



104

Withholding
withdrawing
treatment



105

DNR
DNH
PEG / CANH
Dialysis



106

Other refusals
Antibiotics
Etc.



107

Table 1. *Percentage of Respondents Reporting That Ethical Dilemmas With Respect to the Following Issues Occur at Their Facilities (N = 93)*


Issues	n (%)
Assessing residents' decision-making capacity	71 (79)
Do not resuscitate decisions	70 (78)
Do not hospitalize decisions	70 (77)
Tube feeding issues	67 (74)
Implementing advance directives	63 (70)
Ascertaining resident health care preferences	60 (68)
Identifying surrogate decision-makers	53 (59)
Withholding/withdrawing life sustaining treatments	44 (48)

and professional expertise. (*J Am Med Dir Assoc* 2005; 6: 68-75)




108

Conflicting evidence
of R wishes
AD
Surrogate



109

Conflicting evidence
of R wishes
POLST
Surrogate



110



MD *Care forward.*

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111

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/06/2021
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER Lorien Health Systems - Columbia		STREET ADDRESS, CITY, STATE, ZIP CODE 6334 Cedar Lane Columbia, MD 21044	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG F 0622	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
Level of Harm - Minimal harm or potential for actual harm	A Social Services note dated 2/4/20 at 3:56 PM noted that the resident's responsible party had expressed some issues with the resident's care. A Social Services note dated 2/5/20 at 9:27 AM noted, the resident's responsible party requested changes to Resident RZ's MOLST. The facility referred the matter of changing the MOLST to the <u>Ethics</u> Committee.		

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112

More controversial
VSED
MAID



113

10 US jurisdictions




114



115



116

Patient died at		
Home (patient, family or friend)	177	(94.1)
Assisted living or foster care facility	5	(2.7)
Nursing home	4	(2.1)
Hospital	0	(0.0)
Hospice facility	1	(0.5)
Other	1	(0.5)



117

Patient died at		
Home (patient, family or friend)	177	(94.1)
Assisted living or foster care facility	5	(2.7)
Nursing home	4	(2.1)
Hospital	0	(0.0)
Hospice facility	1	(0.5)
Other	1	(0.5)



118

CALIFORNIA END OF LIFE OPTION ACT 2019 DATA REPORT



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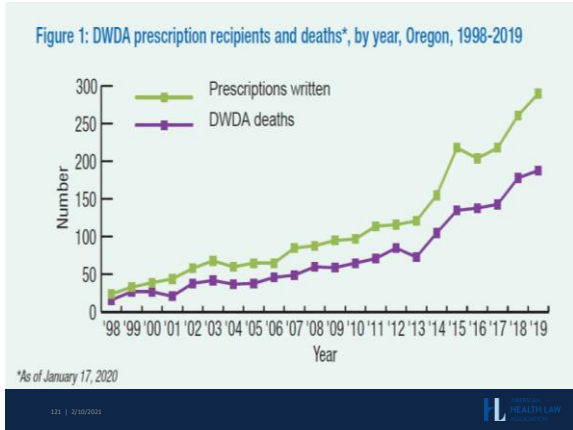
119

Location Where Aid-in-Dying Drugs were Ingested	N	(%)
Private Home	357	(88.1)
Assisted-Living Residence	29	(7.2)
Nursing Home	12	(3.0)
In-patient Hospice Residence	4	(1.0)
Acute Care Hospital	1	(0.2)
Other	2	(0.5)

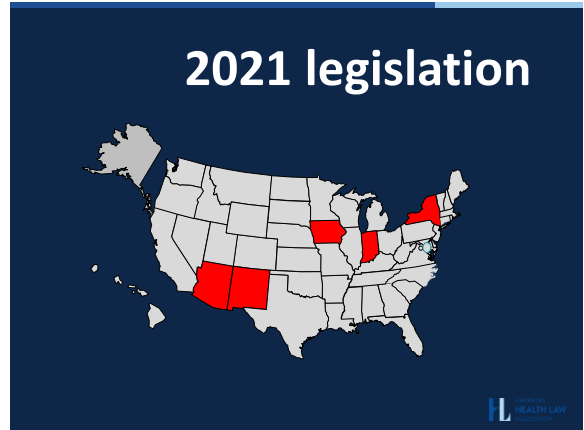
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120



121



122

Policy &
procedures

123 | 2/10/2021

123

VSED

124 | 2/10/2021

124

Voluntarily
Stopping
Eating &
Drinking

125 | 2/10/2021

125

3

126 | 2/10/2021

126

Physiologically
able to take food
& fluid by mouth



127

Voluntary,
deliberate
decision to stop



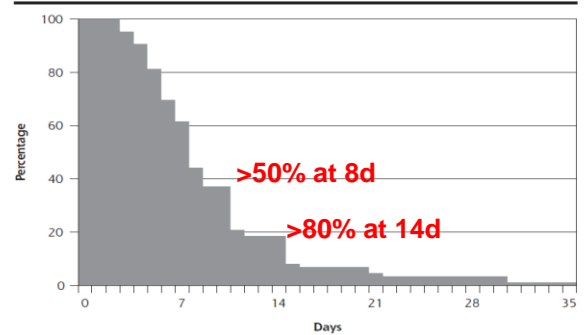
128

Intent
death from
dehydration



129

Figure 1. Cumulative survival curve for duration until death after start of VSED.



[Ann Fam Med 2015;13:421-428. doi: 10.1370/afm.1814.](#)



130

DEMAND

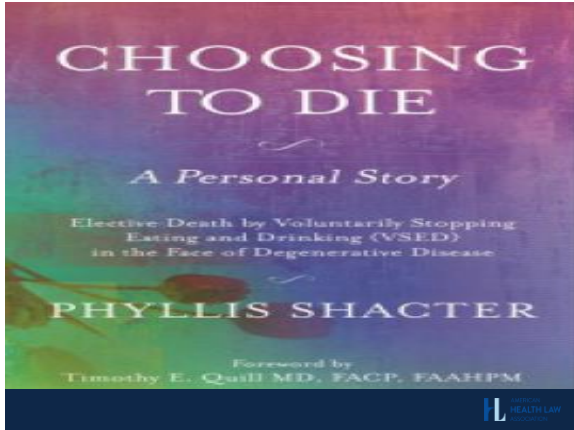


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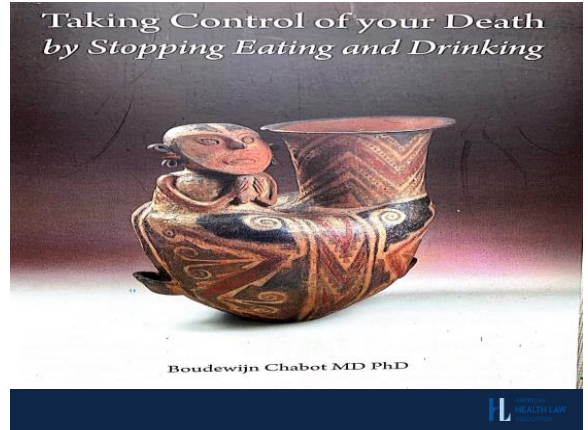
Books



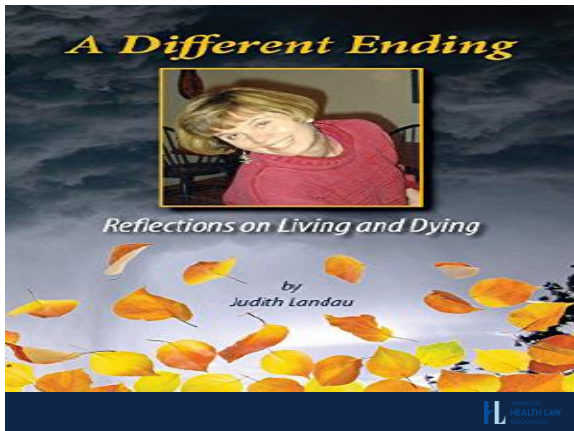
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133



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135



136



Films - Dying Wish

137



138



139



140

The NEW ENGLAND JOURNAL of MEDICINE

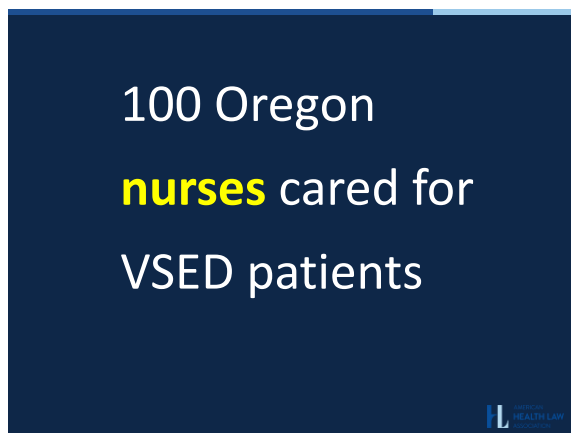
SPECIAL ARTICLE

Nurses' Experiences with Hospice Patients Who Refuse Food and Fluids to Hasten Death

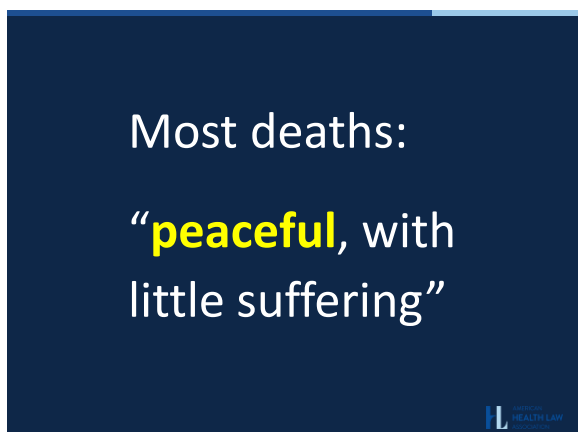
Linda Ganzini, M.D., M.P.H., Elizabeth R. Goy, Ph.D., Lois L. Miller, Ph.D., R.N., Theresa A. Harvath, R.N., Ph.D., Ann Jackson, M.B.A., and Molly A. Delorit, B.A.



141



142




143



144

Even though MAID available, “almost twice” chose VSED



145

JAMA Internal Medicine | Special Communication | HEALTH CARE POLICY AND LAW

Voluntarily Stopping Eating and Drinking Among Patients With Serious Advanced Illness—Clinical, Ethical, and Legal Aspects

Timothy E. Quill, MD; Linda Ganzini, MD, MPH; Robert D. Truog, MD; Thaddeus Mason Pope, JD, PhD

JAMA Internal Medicine January 2018 Volume 178, Number 1 123



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Journal of the American Geriatrics Society



SPECIAL ARTICLE:
PALLIATIVE PRACTICE POINTERS

Voluntary Stopping Eating and Drinking

John W. Wax, MD, Amy W. An, MD, Nicole Kosier, MD, and Timothy E. Quill, MD



147

Professional society endorsements



148

POSITION STATEMENT



Nutrition and Hydration at the End of Life

Effective Date: 2017
Status: Revised Position Statement
Written by: ANA Center for Ethics and Human Rights
Adopted by: ANA Board of Directors



149



The Vision and Voice of Women in Medicine since 1915

American Medical Women's Association



150

JOURNAL OF PALLIATIVE MEDICINE
Volume 20, Number 1, 2017
Mary Ann Liebert, Inc.
DOI: 10.1089/jpm.2016.0290

Position Statement

International Association for Hospice and Palliative Care Position Statement: Euthanasia and Physician-Assisted Suicide



151



2019
THE SOCIETY
FOR POST-ACUTE AND
LONG-TERM
CARE MEDICINE



152

VSED is an
EOL exit
option



153

Broadly
accepted



154

Evidence
based



155

BUT



156

Staff **unsure**
may or must
honor



157

That's VSED
patient **with capacity**
refuses food & fluid



158

Advance
VSED



159

Complete AD, today



160

Direct VSED
in **future**



161

At a **point**
Pt specifies



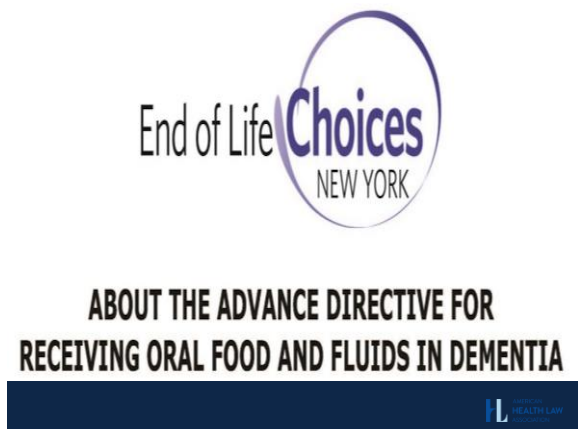
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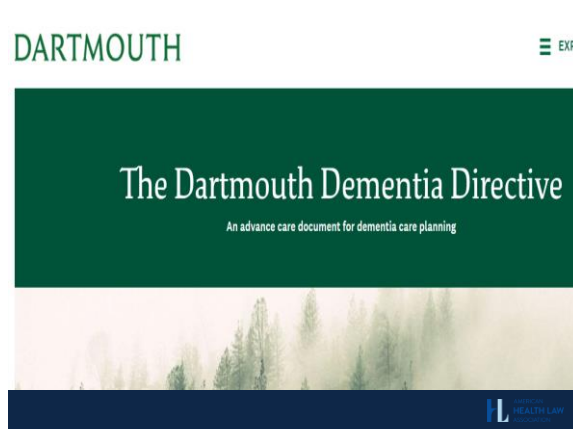
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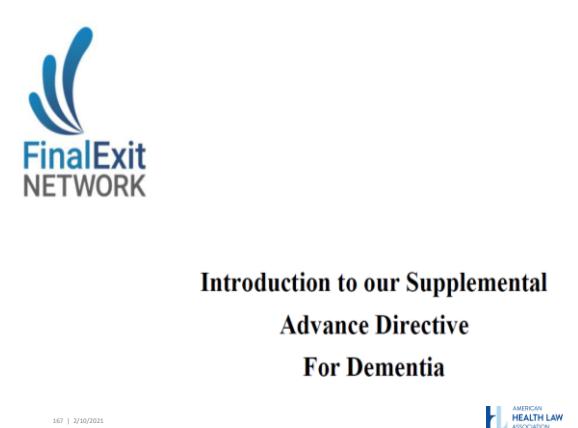
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165



166



167



168

Focus on needs of
current self

Not wishes of
prior self



169

BUT



170



171

“health care”
“**personal
circumstances**”

Vermont § 9702(a)(12)



172

“services to assist
in **activities of
daily living**”

Vermont §§ 9702(a)(5), 9701(12)



173

CEC



174

1. Is AD **clear**
2. AD apply **now**
3. Has Pt **revoked**
by current
request



175

4

Surrogate Decisions



176

When the R **lacks**
decision making
capacity



177

Identify
surrogate



178

Who **best** knows
and cares about
the R



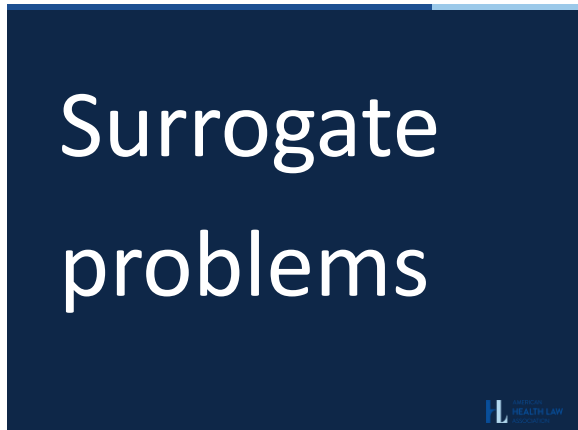
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Support
surrogate

When making
tough decisions



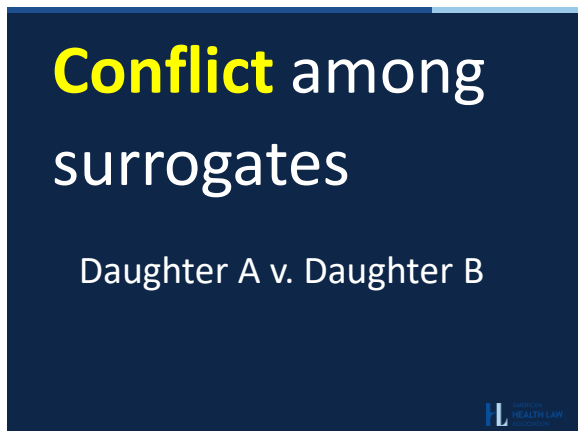
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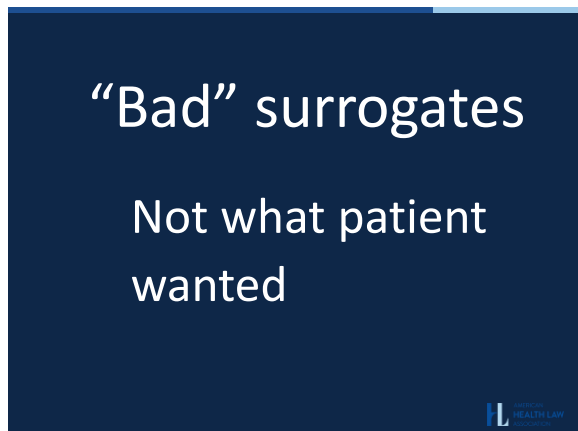
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182



183



184



185

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER Bridgewater Center for Rehab & Nursing L.L.C		STREET ADDRESS, CITY, STATE, ZIP CODE 159 163 Front Street - Box 765 Binghamton, NY 13902	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**		

The American Health Law Association logo is in the bottom right corner.

186

No available surrogate



187



Healthcare facility has incapacitated patient with no available surrogate



188

Increasingly **common** situation



189

Patient **needs** treatment



190

BUT



191

No capacity
No surrogate



192

Patient
cannot
consent



193

Nobody
else to
consent



194

**Various
terms**



195

“unrepresented”
“adult orphan”



196

Patient w/o proxy
Unbefriended



197

Most prevalent

“unbefriended”



198

Incapacitated and Alone: Health Care Decision-Making for the Unbefriended Elderly

Naomi Karp and Erica Wood



American Bar Association
Commission on Law and Aging

July 2003



199

om -
buds -
man The National Long-Term Care
Ombudsman Resource Center

Advocating for the Unbefriended Elderly

An Informational Brief

August 2010

Jessica E. Brill Ortiz, MPA



200

AGS Position Statement: Making Medical Treatment Decisions
for Unbefriended Older Adults



Leading Change. Improving Care for Older Adults.



201

Big problem



202

3 - 4 %

U.S. nursing home
population



203

Temporarily unrepresented



204

Not just big, but

Growing problem



205

4 key factors

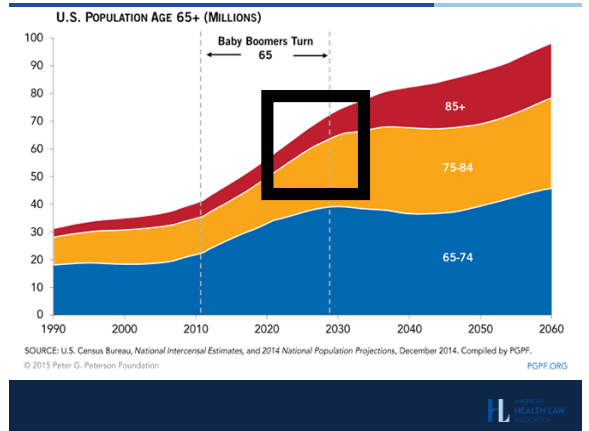


206

1



207



208

2




209

AARP Public Policy Institute

10,000,000 boomers live alone

The Aging of the Baby Boom and the Growing Care Gap:
A Look at Future Declines in the Availability of Family Caregivers



210



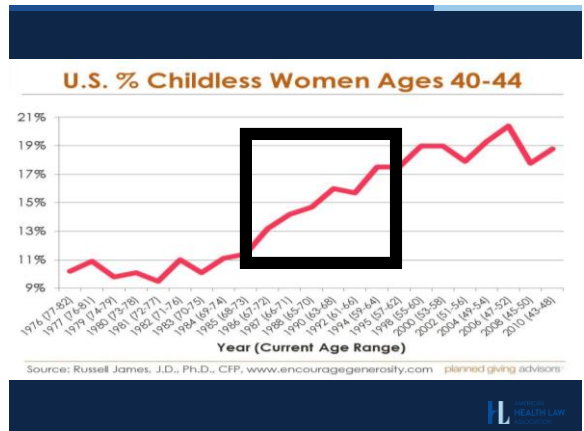
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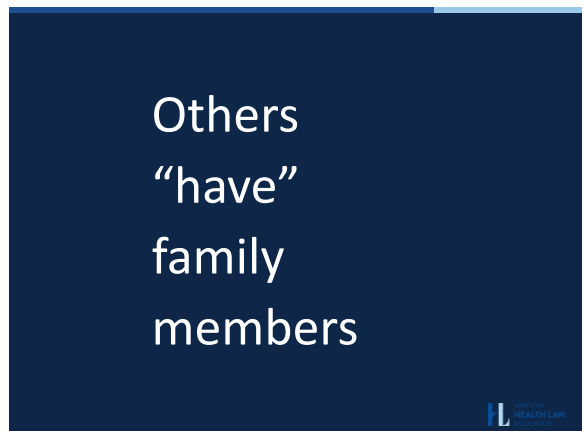
213



214



215



216

Able but
unwilling



217

No **contact** (e.g.
LGBT, homeless,
criminal)



218

Willing but
unable



219

SDM lacks
capacity



220

We have **many**
unrepresented



221

What's the
problem



222

Risks & Harms



223

Cannot advocate for self



224

Have **no** substitute advocate



225

POSITION STATEMENT

Making Treatment Decisions for Incapacitated Older Adults Without Advance Directives

AGS Ethics Committee*

“highly vulnerable” “most vulnerable”



226

GUARDIANSHIP FOR VULNERABLE ADULTS IN NORTH DAKOTA: RECOMMENDATIONS REGARDING UNMET NEEDS, STATUTORY EFFICACY, AND COST EFFECTIVENESS

WINSOR C. SCHMIDT*

“unimaginably helpless”



227

Problem



228

Nobody to authorize treatment



229

How do clinicians respond?



230

2 common responses



231



Journal of Aging & Social Policy

ISSN: (Print) (Online) Journal homepage: <https://www.tandfonline.com/loi/wasp20>

Unrepresented Adults Face Adverse Healthcare Consequences: The Role of Guardians, Public Guardianship Reform, and Alternative Policy Solutions

Casey C. Catlin, Heather L. Connors, Pamela B. Teaster, Erica Wood, Zachary S. Sager & Jennifer Moye

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232

1



233

Under-treatment



234

Reluctant to
act without
consent



235

Wait



236

Until
emergency
(implied consent)



237

BUT

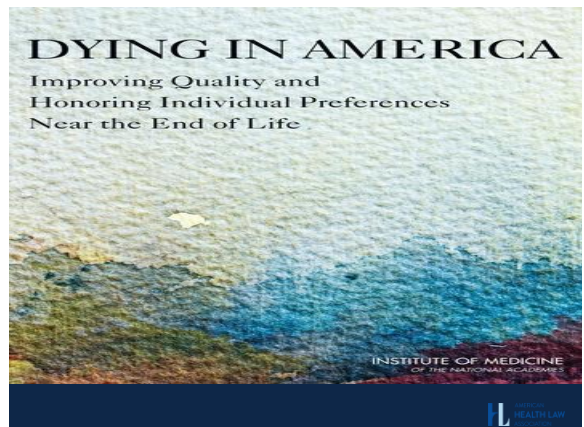


238

Longer period
suffering
Increases risks



239



240

Ethically “**troublesome** . .
. wait until . . . condition
worsens into an
emergency”



241

2



242

Over- treatment



243

Fear liability
Fear regulatory
sanctions



244

Treat aggressively



245

BUT

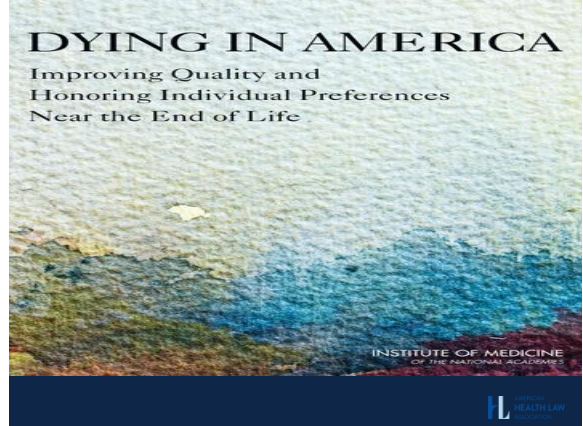


246

Burdensome
Unwanted



247



248

“**compromises** . . .
consideration of
patient preferences or
best interests”



249

Takeaway



250

No consent → Bad
conduct



251

Need a
consent
mechanism



252

Who decides?

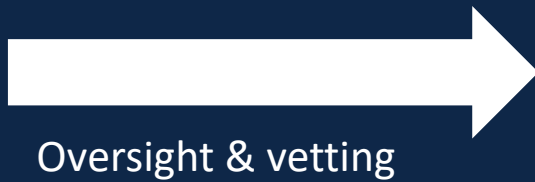


253

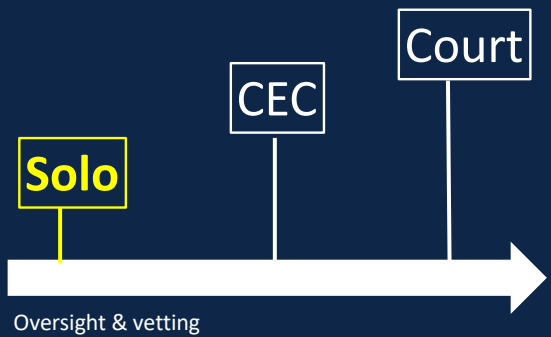
Variability



254



255



256

Solo clinician



257

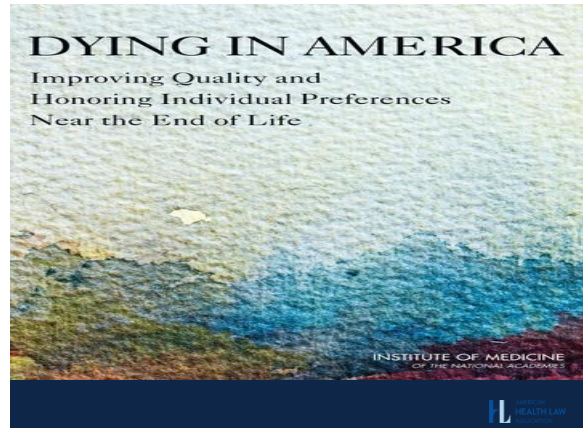
Most **common** approach



258



259



260

“Having a **single health professional** make unilateral decisions . . .”

261

“**ethically unsatisfactory** in terms of protecting patient autonomy and establishing transparency.”

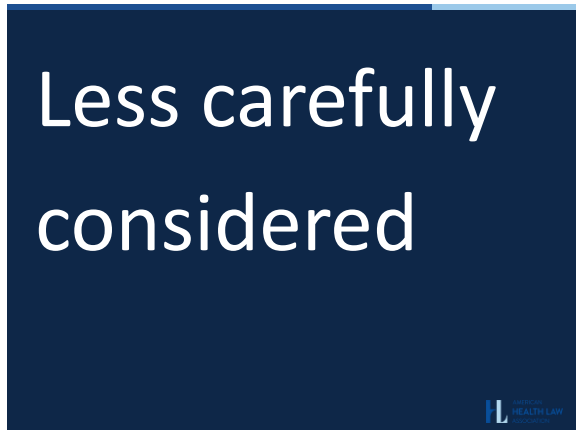
262

2 reasons

263

Bias & COI unchecked

264



265



266

Department of Health & Human Services
Centers for Medicare & Medicaid Services

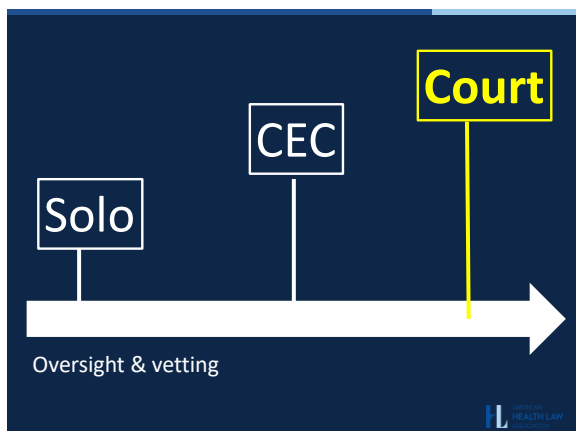
Printed: 02/09/2021
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER Muscogee Manor & Rehabilitation Cr		STREET ADDRESS, CITY, STATE, ZIP CODE 7150 Manor Road Columbus, GA 31907	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG F 0551	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) Give the resident's representative the ability to exercise the resident's rights.		

267

Based on record review and staff interview, the facility failed to ensure that Resident (R)#53 had a legal surrogate to exercise her resident's rights. The facility was aware that R#53 did not have a family member or responsible party and failed to take steps to obtain a legal surrogate.

268



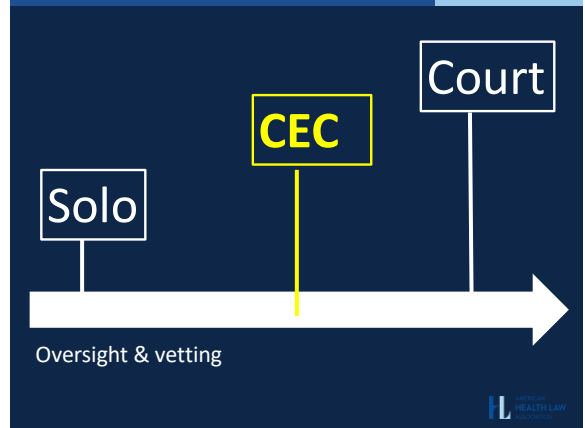
269

Slow, tough getting public guardian

270



271



272



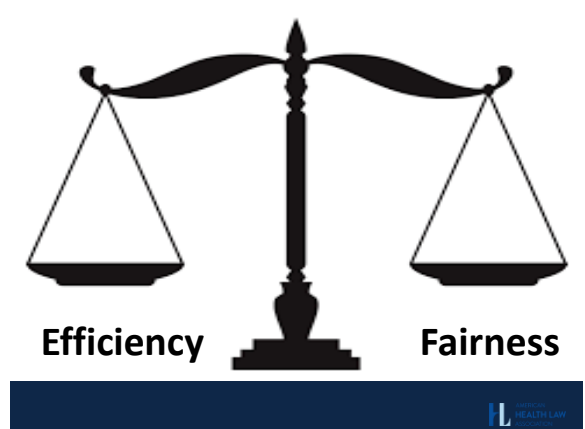
273

Some mechanisms are **too fast**

274

Some mechanisms are **too slow**

275



276



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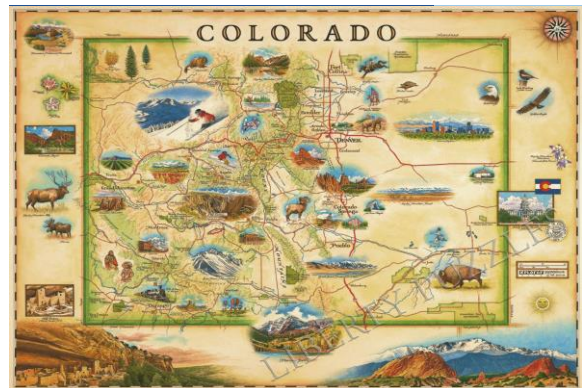
277

“An attending health care provider **may designate** another willing physician, advanced practice registered nurse, or physician assistant to make health care treatment decisions as a patient’s **proxy decisionmaker**”

278



“consulted with and obtained a consensus on the proxy designation with the **medical ethics committee** of the health care facility where the patient is receiving care”



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280



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281

“designated physician may make health care decisions . . . consults with and obtains the recommendations of an **institution's ethics mechanism**”

282





283

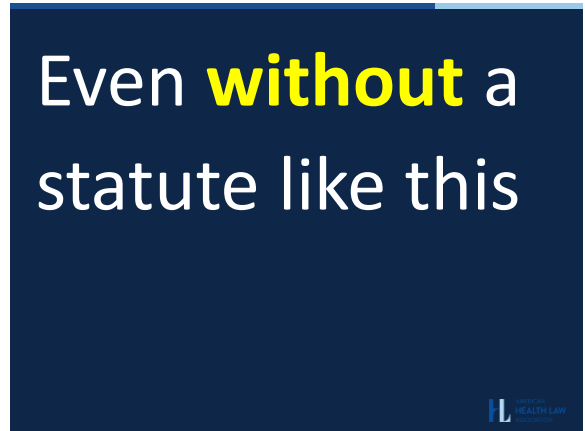


Uniform Law Commission

284



285



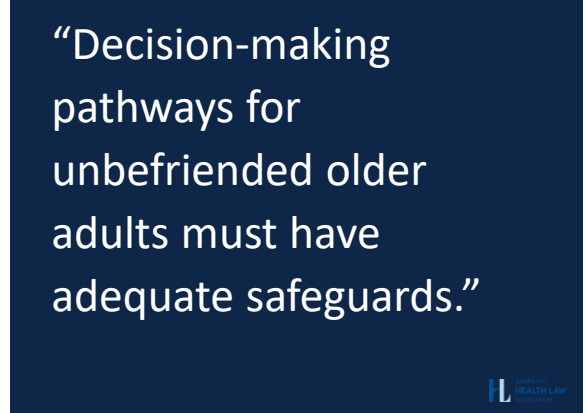
286

AGS Position Statement: Making Medical Treatment Decisions for Unbefriended Older Adults

Timothy W. Farrell, MD, AGSF,^{1,2} Eric Widera, MD,^{3,4} Lisa Rosenberg, MD,⁵ Craig D. Rubin, MD, AGSF,⁶ Anand D. Naik, MD,^{7,8} Ursula Braun, MD, MPH,^{7,8} Alexia Torke, MD, MS,⁹ Ina Li, MD,¹⁰ Caroline Vitale, MD, AGSF,^{11,12} Joseph Shega, MD,^{13,14} for the Ethics, Clinical Practice and Models of Care, and Public Policy Committees of the American Geriatrics Society

JAGS 65:14-15, 2017

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288

“external entity such as an **ethics committee** . . . review treatment options and to consent to the proposed treatment decision”



289

AMERICAN THORACIC SOCIETY DOCUMENTS

Making Medical Treatment Decisions for Unrepresented Patients in the ICU

An Official American Thoracic Society/American Geriatrics Society Policy Statement

Thaddeus M. Pope, Joshua Bennett, Shannon S. Carson, Lynette Cederquist, Andrew B. Cohen, Erin S. DeMartino, David M. Godfrey, Paula Goodman-Crews, Marshall B. Kapp, Bernard Lo, David C. Magnus, Lynn F. Reinke, Jamie L. Shirley, Mark D. Siegel, Renee D. Stapleton, Rebecca L. Sudore, Anita J. Tarzian, J. Daryl Thornton, Mark R. Wicclair, Eric W. Widera, and Douglas B. White; on behalf of the American Thoracic Society and American Geriatrics Society

THIS OFFICIAL POLICY STATEMENT WAS APPROVED BY THE AMERICAN THORACIC SOCIETY FEBRUARY 2020 AND THE AMERICAN GERIATRICS SOCIETY JANUARY 2020

200 | 2/10/2021



290

Manage decision-making for unrepresented patients using input from a **diverse interprofessional, multidisciplinary committee** rather than ad hoc by treating clinicians;



291

Recap



292

Sometimes
required
(by statute or regulation)



293

Widely
recommended
(by professional societies)



294

Whether
delegated a
role **or** not



295

Useful
(in solving
ethical issues)



296

**How to
start**



297

The Ethics Committee
in the SNF: Where to
begin?

Step one: RESEARCH



298

Recommended
Reading #1:
(detailed info in handout)

Beauchamp and Childress
“Principles of Biomedical
Ethics” (paperback)



299

Recommended
Reading #2:
(detailed info in handout)

Post and Blustein
“Handbook for Health Care
Ethics Committees”
(paperback)



300

Recommended Reading #3: (detailed info in handout)

AMDA 2006 White Paper : The Role of a facility Ethics Committee in Decision-Making at the End of life

<https://paltc.org/amda-white-papers-and-resolution-position-statements/role-facility-ethics-committee-decision-making>



301

Recommended Reading #4: (handout)

Karl Steinberg, MD, CMD “Bioethics in Post-Acute and Long Term Care” Provider Magazine Feb 2019

<https://paltc.org/amda-white-papers-and-resolution-position-statements/role-facility-ethics-committee-decision-making>



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More research:

Experienced and knowledgeable people



303

Finding qualified people to help:

Local hospital bioethics committee --
Even if they can't help directly, they may be able to make a referral

Independent bioethicists---
(ASBH certification commission may be a useful source)

<https://asbh.org/certification/hcec-certification>



304

Next step: Define what your committee will do

Education
Policy Review
Case Studies



305

Next step: Define what your committee will do

Decisions
Recommendations (based upon ethically acceptable alternatives)



306

Essential Committee Members

Medical Director
 Director of Nursing
 Individual with
 background/experience/education
 in bioethics



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Other Potential Committee Members

Licensed Nurse(s) (RN/LVN/LPN)
 Social Worker
 Clergy/Chaplain
 2nd MD (not subject patient's attending)
 Other health care disciplines
 Community Member (confidentiality
 compliance required)



308

Lawyers?
 Optional/helpful but
 should not be
 regular facility
 counsel



309

Law can inform
 ethics but is not
 ethics



310

Formal clinical case
 consultation?
 Not for a general SNF
 ethics committee



311

Formal clinical case
 consultation service
 may be available –
 evaluate contractual
 and legal issues.



312

How big?
What feels right?
Start small

Subcommittees may
be useful.



313

Next Step:
Institutional policy

Co-operative effort:
Administration/Initial
members/Legal



314

NEXT STEP:

Get to work!



315

Ethics Related Policy Review

End of life care,
Patient rights,
Confidentiality,
Healthcare decision making
Resource allocation



316

Education:

Committee Members
Facility Staff
Outreach



317

Case Review:

Published case studies
(at first)

Current and
retrospective in-house
cases



318

And finally:

Maintain member
engagement and
enthusiasm!



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Our Vision

To lead health law to excellence through education, information, and dialogue.

Our Mission

To provide a collegial forum for interaction and information exchange to enable its members to serve their clients more effectively; to produce the highest quality, nonpartisan, educational programs, products, and services concerning health law issues; and to serve as a public resource on selected health care legal issues.

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—from a declaration of the American Bar Association.



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